STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655		A. BUILDING 02			COMPL	3) DATE SURVEY COMPLETED 10/14/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				400 W S	NDDRESS, CITY, STATE, ZIP CODE SEVENTH ST I MANCHESTER, IN46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0000	and State Licent conducted by the Department of accordance with Survey Date: In 10/14/11 Facility Number Provider Number Alm Number: Surveyor: Amy Code Specialist At this Life Safer Peabody Retire was found not Requirements of Medicare/Medi Subpart 483.70 from Fire and the National Fire Association (NF Code (LSC), Chell Health Care October 16.2) This facility con Care Center So	h 42 CFR 483.70(a). 0/13/11 and r: 000485 er: 155655 100291190 Kelley, Life Safety ety Code survey, ment Community in compliance with for Participation in caid, 42 CFR 0(a), Life Safety he 2000 edition of re Protection FPA) 101, Life Safety apter 18, New cupancies and 410 nsists of Health uth a fully		0000			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	3	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

233V21

Facility ID:

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If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655		A. BUII	LDING	02 	(X3) DATE S COMPLI 10/14/20	ETED		
		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST						
Y RETIREMENT C	OMMUNITY		NORTH	MANCHESTER, IN46962				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
Type II (111) condended the Care Not Memory Enhance which are both sprinklered build (111) construct has a fire alarm smoke detection areas open to the resident rooms capacity of 192 of 163 at the till Quality Review by I Code Specialist-Medical The facility was compliance with aforementioned	onstruction, and rth and Smock cement Center a one story fully lding of Type II cion. The facility a system with an in corridors, he corridor and . The facility has a and had a census me of this survey. Robert Booher, Life Safety dical Surveyor on 10/19/11.							
duration is provide 18.2.9.1 Based on obser interview, the f ensure 2 of 2 e fixtures of at le duration were t	vation and accility failed to mergency light ast a 1½ hour sested annually in	K	0046	test on all battery powered emergency lighting.2. All residents are affected equally Facility Technician will use the new form we have created we doing the annual 90 minute.	y 3. ie hen	11/13/2011		
	PROVIDER OR SUPPLIER OY RETIREMENT CO SUMMARY ST (EACH DEFICIENT REGULATORY OR Sprinklered two Type II (111) co Health Care No Memory Enhance which are both sprinklered bui (111) construct has a fire alarm smoke detection areas open to to resident rooms capacity of 192 of 163 at the ti Quality Review by I Code Specialist-Med The facility was compliance with aforementioned requirements a following: Emergency lighting duration is provide 18.2.9.1 Based on obser interview, the fi ensure 2 of 2 e fixtures of at le duration were t	DEPOSITION NUMBER: 155655 PROVIDER OR SUPPLIER DY RETIREMENT COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Sprinklered two story building of Type II (111) construction, and Health Care North and Smock Memory Enhancement Center which are both a one story fully sprinklered building of Type II (111) construction. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and resident rooms. The facility has a capacity of 192 and had a census of 163 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/19/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.	DENTIFICATION NUMBER: 155655 R. BUIL REQUIDER OR SUPPLIER DY RETIREMENT COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) sprinklered two story building of Type II (111) construction, and Health Care North and Smock Memory Enhancement Center which are both a one story fully sprinklered building of Type II (111) construction. 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The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 emergency light fixtures of at least a 1½ hour duration were tested annually in	DENTIFICATION NUMBER: 155655 ROVIDER OR SUPPLIER PROVIDER OR SUPPLIER SY RETIREMENT COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Sprinklered two story building of Type II (111) construction, and Health Care North and Smock Memory Enhancement Center which are both a one story fully sprinklered building of Type II (111) construction. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and resident rooms. The facility has a capacity of 192 and had a census of 163 at the time of this survey. 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STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN46962 ID PROFIEST TO SEMENTICAL STATEMENT ON THE ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN46962 ID PROFIEST TO SEMENTICAL STATEMENT ON THE ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN46962 ID PROFIEST TO SEMENTICAL TO SEMENTICAL STATEMENT ON THE ADDRESS CITY, STATEMENT ON THE ADDRESS CITY STATEMENT ON THE A	OF CORRECTION IDENTIFICATION NUMBER: 156655 ROVIDER OR SUPPLIER PY RETIREMENT COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MIST BE PERCEDDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Sprinklered two story building of Type II (111) construction, and Health Care North and Smock Memory Enhancement Center which are both a one story fully sprinklered building of Type II (111) construction. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and resident rooms. 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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655		LDING	NSTRUCTION 02	(X3) DATE COMPL 10/14/2	ETED		
NAME OF I	PROVIDER OR SUPPLIER	.	STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST					
PEABOD	Y RETIREMENT C	OMMUNITY		MANCHESTER, IN46962				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	requires an aniconducted on a battery powere lighting system 1½ hour dura shall be fully o duration of the records of visu tests shall be k for inspection having jurisdic practice could staff and visito Findings included Based on an important of Factor of	hting Equipment hual test shall be every required d emergency n for not less than a tion. Equipment perational for the e test. Written al inspections and tept by the owner by the authority tion. This deficient affect all residents, rs. de: terview with the ilities Services on 2:00 p.m., she has ord of an annual test battery operated ats available for on observations or of Facilities /14/11 at 9:51 ery operated ats were observed in		and date form when complet and turn into the Director of Facility Services4. Director of Facility Services will keep the generator test binder in office monitor this insure that the test is completed and in generator binder	of e e and esting			

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655		ĺ	LDING	NSTRUCTION 02	(X3) DATE S COMPL 10/14/20	ETED
	ROVIDER OR SUPPLIER			400 W S	DDRESS, CITY, STATE, ZIP CODE SEVENTH ST MANCHESTER, IN46962		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ΓE	(X5) COMPLETION DATE
K0062 SS=F	Required automatic continuously main condition and are in periodically. 18.7 25, 9.7.5 Based on interview, the facing maintain the based on 1 of 1 healt systems as required the Standard for Testing and Mawater-Based Fi Systems at 9-6 all backflow prefire protection is be tested annual practice affects the facility recectorerage from system in the number of the protection of Facing and Mawater-Based on record 10/13/11 at 11 annual inspection available for the preventer in the Based on an into Director of Facing 3:15 p.m., no continuously maintains and the preventer of the preventer of facing 3:15 p.m., no continuously maintains and the preventer of facing 3:15 p.m., no continuously maintains and the periodically.	c sprinkler systems are tained in reliable operating inspected and tested .6, 4.6.12, NFPA 13, NFPA riew and record lity failed to ackflow preventers in care sprinkler quired by NFPA 25, or the Inspection, .intenance of re Protection .2.1 which requires eventers installed in system piping shall ally. This deficient all occupants in iving sprinkler the sprinkler mechanical room. e: d review with the lities Services on 1:28 a.m., an on report was not e back flow e mechanical room. erview with the lities Services at	K	0062	1. New company has been hand educated on where the backflow preventers are loca for annual testing.2. All residure affected equally.3. Curre Fire Protection will turn in completed backflow testing pwork directly to the Director Facility Services.4. Director Facility Services will insure the backflow test have been completed and papers filed in Sprinkler & Fire Alarm Inspecion office. Director of Facility Services will monitor this to insure test is completed.	ted lents ent aper of of nat n the ction ors ices	11/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 02 A. BUILDING			(X3) DATE SURVEY COMPLETED		
155655		A. BUIL B. WING		<u>-</u>	10/14/2	011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				400 W S	DDRESS, CITY, STATE, ZIP CODE SEVENTH ST MANCHESTER, IN46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0144 SS=F	exercised under lomonth in accordant 3.4.4.1. 1. Based on reinterview, the factorial amount of the ensure a month of the ensure at not less than the engant of the ensure	cord review and acility failed to ally load test for 1 of enerators was g one of the three ods: under verature conditions, a 30% of the ver Supply (EPS) ag, or loading that aninimum exhaust es as by the Chapter 3–4.4.1.1 uires monthly rators serving the ctrical system to be with NFPA 110. of NFPA 110 ator sets in Level 1 vice to be exercised onthly, for a minutes, using	K0	0144	1. 1. We are purchasing a lobank to insure that we run at for monthly load testing. 2. resident are affected equally. 3. The load bank that we havorder has to be made by manufacture and will be delivered in about 8 week which should be around the I part of December or first par January 2012. Once delvere will be installed by Disko Electric. Facility Technician turn the generator check list the Director of Facility Service weekly signed and dated. 4. Director of Facility Services wonitor this weekly to assure being completed. A waiver we submitted on 11/7/11 as an addendum to this plan of correction.2. 1. We will instairemote manual stop switch of emergency generator in a different area from the generator. 2. All residents are affected equally 3. The romomanual stop will be a permar fixture. 4. Director of Facility Services will monitor when derounds.	30% All re assast t of ed it will into ce vill e it is vas Il a n the	11/13/2011

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M) MULTIPLE CONSTRUCTION			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	02	COMPL		
	155655		B. WING 10/14/2011					
NAME OF I	PROVIDER OR SUPPLIER	3	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					SEVENTH ST			
PEABOD	Y RETIREMENT C	OMMUNITY		NORTH	H MANCHESTER, IN46962			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	†	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		it not less than 30						
	percent of the	EPS nameplate						
	rating.							
	_	t maintains the						
	minimum exha							
	•	as recommended by						
	the manufactu	rer.						
	The date and t	ime of day for						
	required testin	g shall be decided						
	by the owner, l	based on facility						
	operations. Th	nis deficient practice						
	could affect all	residents, staff and						
	visitors.							
	Findings includ	de:						
	Based on revie	w of the generator						
	log titled "Gen	erator Weekly Check						
	List" with the D	Director of Facilities						
	Services on 10	/13/11 at 11:30						
		rator log showed a						
	_	est for the past						
		for a thirty minute						
		id not indicate if the						
		an under operating						
	_	onditions or a thirty						
		plate rating load test						
	·	e minimum exhaust						
		res. Based on an						
	_	the Director of						
		ces at the time of						
	record review,							
		n was available for						
	documentation	i was available IUI						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/14/2011	
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STA	ΓΕ, ZIP CODE	<u> </u>	
PEABOD	Y RETIREMENT C	OMMUNITY			EVENTH ST MANCHESTER	, IN46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE!	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIAT LIENCY)	Ē	(X5) COMPLETION DATE
	review.							
	3.1-19(b)							
	remote manual requires emerging providing power lighting system tested and mai accordance with Standard for Error Standby Power 110, 1999 edit requires Level have a remote of a type similar station located housing the prospect of Standard for and Use of Standard for and	facility failed to emergency sequipped with a lastop. LSC 7.9.2.3 gency generators er to emergency as shall be installed, intained in h NFPA 110, mergency and Systems. NFPA ion, 3–5.5.6 lainstallations shall manual stop station ar to a break-glass outside the room ime mover. NFPA or the Installation cionary Combustion as Turbines, 1998 a.2(c) requires horsepower or vision for shutting the at the engine and						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID: 2	 233V21	Facility II	D: 000485	If continuation sh	eet Pac	ge 7 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655		A. BUILDING		O2	(X3) DATE S COMPL 10/14/20	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF	ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	Findings includ	e:						
	10/14/11 during facility from 9:3 p.m., the only remergency generated on the generated not have a remethe emergency on an interview of Facilities Seron 10/14/11, to	lities Services on ag a tour of the 30 a.m. to 1:35 manual stop for the erator was located or. The facility did ote manual stop for generator. Based with the Director vices at 10:12 a.m.						
K0143 SS=E	wherein patients a treated by a separ 1-hour fire-resistive (b) in an area that sprinklered, and he flooring; and (c) in an area post transferring is occur	any portion of a facility re housed, examined, or ation of a fire barrier of e construction; is mechanically ventilated, as ceramic or concrete ed with signs indicating that urring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2	K0143		All fire rating doors will ha	ve	11/13/2011	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	A. BUI	LDING	04	(X3) DATE COMPL 10/14/2	ETED	
	PROVIDER OR SUPPLIER		B. WING TO/ 14/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN46962					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Enhancement of transferring of separated by a hour fire resist. This deficient pany resident near the manual series of the small portable plate providing fire rating of the removed from oxygen storage.	center used for oxygen was fire barrier of 1 ive construction. Oractice could affect ear the Memory citchen. de: de: deservation with the ilities Services on 1:45 a.m., there was age room with two ygen containers ry Enhancement on an interview 1, the oxygen sused to transfer the liquid containers ble tanks. The metal information on the de door had been the door to the			metal plates in place and vis to read the fire rating.2. All residents are affected equall Central Indiana Hardware wi and metal plate the fire rating doors that are missing metal plates. Facility Technician wrounds every 6 months to chifire rated doors to insure that metal plates are in place. Fatechnician will sign off and of in the Preventive Maintenance Supervisor will check Preventive Maintenance Supervisor will check Preventive Maintenance book monthly to insure that these rounds are being completed every 6 months are being completed every 6 months.	y.3. Il rate g vill do eck t acility late ce		

000485